Michiana Hematology Oncology, PC

Patient Information

Patient's Last Name:	First:	Middle:	Nickname (what you like to be called):
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Social Security Number:		Date of Birth:	Age:
Street Address:		City:	State: / Zip Code:
County of Residence:	Home Phone: *(w/ area code)*	Mobile Phone: *(w/ area code)*	Email Address:
Emergency Contact:	Phone: *(w/ area code)*		Relationship:
Appt. Reminder Contact Preference: *(check all that apply)* ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Text			
Language: ☐ English ☐ Spanish ☐ French ☐ German ☐ Other _____ ☐ Prefer not to answer		Ethnicity: ☐ Hispanic / Latin ☐ Not Hispanic / Latino ☐ Prefer not to answer	
Race: ☐ African American / Black ☐ American Indian / Alaskan Native ☐ Asian ☐ Pacific Islander / Hawaiian Native ☐ White ☐ Other ☐ Prefer not to answer			
Patient Occupation:	Patient Employer:		
Employer's Address:	City:	State: / Zip Code:	Employer's Phone:
Retired: ☐ Y ☐ N	If yes, retired from:		
Do you live in an assisted living residence or nursing home? ☐ Y ☐ N			
Name of facility:	Address:		
City: / State:	Zip Code:	Phone:	

Preferred Pharmacy

Name of Pharmacy:		Address:	
City:	State:	Zip Code:	Phone:

Spouse's Information-If Cardholder

Spouse's Last Name:	First:	Middle:	DOB:	Soc. Sec. Number:
Employer:	Address:			Employer's Phone:
Retired: ☐ Y ☐ N	If yes, retired from:			Mobile Phone:

Pt ID: _____

This Information Will Remain Confidential

Staff Initials: _____

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Policyholder Information

If patient is not the policyholder, this section must be filled out.

Last Name:	First:	Middle:	Address is Same as Patient's: ☐ Y ☐ N
Street Address:		City:	State: / Zip Code:
Date of Birth:	Social Security Number:	Home Phone:	Mobile Phone:
Relation to Patient	Employer:	Employer's Address:	
Employer's City:	State:	Zip Code:	Employer's Phone:

Special Information

Is there any additional information we should know when providing your care?

Physician

1. Primary Physician:	
2. Referring Physician:	
3. Surgeon:	
4. Other	
5. Other	

Medical History

Normal Weight	Current Weight	Current Height	Weight Gain/Loss Amount	Duration of Gain/Loss

Current Health State: *(check all that apply)*

☐ Loss of Appetite	☐ Bleeding from nose	☐ Diarrhea	☐ Headaches
☐ Fatigue	☐ Prone to sunburn	☐ Nausea / Vomiting	☐ Hot flashes
☐ Fever	☐ Changes in moles/freckles	☐ Rectal Bleeding	☐ Bruising
☐ Night sweats	☐ Chest pain	☐ Blood in urine	☐ Blood Clots
☐ Weight loss	☐ Coughing up blood	☐ Sexually active	☐ Other: _____
☐ Weight gain	☐ Shortness of breath	☐ Muscle weakness	☐ Other: _____
☐ Vision change	☐ Constipation	☐ Dizziness	☐ Other: _____

Reason for Today's Visit: _____

Current Medications		
Medication	**Dosage / Frequency**	**Purpose of Medication**

Please list all allergies to medications, food, or other:		
1.	2.	3.
4.	5.	6.
7.	8.	9.

Vaccination Record	
Date of last influenza vaccination: _____	Date of last pneumococcal vaccination: _____

Previous Cancer History				
Year	**Diagnosis Or Site**	**Chemotherapy** (list medications)	**Radiation**	**Surgery**
			☐	☐
			☐	☐
			☐	☐

Previous Surgeries		
Year:	**Surgery Performed:**	**Hospital:**

Personal Health History *(check all that apply)*			
☐ Heart Disease	☐ Kidney Disease	☐ Osteoporosis	☐ Thyroid Disease
☐ High Blood Pressure	☐ Broken Bones	☐ Stroke	☐ Diabetes
☐ Arthritis	☐ Polyps of Colon	☐ Depression	☐ Breast Lumps
☐ Pneumonia or TB	☐ Cancer	☐ Skin Infection	☐ Urinary Infections
☐ Sinus Infection	☐ Anemia	☐ Seizures	☐ Hepatitis
☐ Asbestos Exposure	☐ Pacemaker	☐ Other: _____	☐ Other: _____

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History of Tobacco and Alcohol Use *(All Patients)*

Do you drink: ☐ Y ☐ N	How Often? ☐ daily ☐ frequently *(several times a week)* ☐ socially *(few times a month)*	For how many years?

Please classify smoking status: ☐Current every day smoker ☐Former smoker ☐Currently unknown ☐Current some day smoker ☐Never a smoker ☐History unknown

How many packs a day: _____	Do you use smokeless tobacco: ☐ Y ☐ N
What year did you start smoking? _____	If you quit what year? _____
Would you like to quit? ☐ Y ☐ N	Would you like cessation counseling? ☐ Y ☐ N

U.S. Military History *(All Patients)*

Did you/are you serving in the Military? ☐ Y ☐ N

How many years did you serve? _____ From _____ To_____

Family History of Cancer: *(please list all relatives diagnosed with cancer)*

Relationship	Maternal/Paternal mother/father	Type of Cancer	Age at Diagnosis	Deceased	Age	Cancer Related?
				☐ Y ☐ N		☐ Y ☐ N
				☐ Y ☐ N		☐ Y ☐ N
				☐ Y ☐ N		☐ Y ☐ N
				☐ Y ☐ N		☐ Y ☐ N
				☐ Y ☐ N		☐ Y ☐ N

Colorectal Screening *(All Patients)*

Has your colon ever been examined by colonoscopy or sigmoidoscopy? ☐ Y ☐ N

If yes: Date of last exam: _____

How many polyps were found :

☐ None ☐ One ☐ 2-10_____ ☐ 11-25_____ ☐ More than 25_____

Prostate Cancer Screening *(Male Patients)*

Have you ever had a PSA (Prostate Specific Antigen) blood test?	☐ Y ☐ N
If so, has the result of the PSA been evaluated?	☐ Y ☐ N
Have you ever had a digital rectal exam? *If yes:* Date of last exam: _____	☐ Y ☐ N
If so, has your digital rectal exam result ever been abnormal?	☐ Y ☐ N
Have you ever had a Bone Scan? *If yes:* Date of Scan _____ Where was scan performed? _____	☐ Y ☐ N

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Menstrual Period History *(Female Patients)*

Age of 1st Menstrual Period:	Are you still having menstrual periods? ☐ Y ☐ N	Date of last PAP:

How long ago was your most recent menstrual period? ☐ Less than 1 month ago
☐ 1-6 months ago ☐ 7-11 months ago ☐ 1 year ago or longer

If you have not had your period in more than 1 year, how old were you at your last period? _____

Why did your periods stop?
☐ Natural menopause ☐ Surgery to remove ovaries or uterus ☐ Chemotherapy or medical treatment

Pregnancy History *(Female Patients)*

Have you ever been pregnant?	☐ Y ☐ N
How many times have you been pregnant?	
How many times have you given birth to a live baby?	
How old were you the first time you gave birth to a live baby?	
How old were you the last time you give birth to a live baby?	
Did you ever breastfeed your children?	☐ Y ☐ N

History of Hormone Use *(Female Patients)*

Have you ever taken birth control hormones?(i.e. pill, patch, injection)	☐ Y ☐ N
Are you currently taking birth control hormones?	☐ Y ☐ N
In total, how many years have you taken birth control hormones?	
Have you ever taken medication to increase your chance of becoming pregnant?	☐ Y ☐ N
In total, how many months did you take medication to become pregnant?	
Have you ever taken Hormone Replacement Therapy (HRT)?	☐ Y ☐ N
If so, how long did you take HRT?	
Have you ever taken Tamoxifen (Nolvadex®)?	☐ Y ☐ N

If yes, please check one: ☐ for treatment of cancer or DCIS ☐ for prevention of cancer

How many years did you take Tamoxifen (Nolvadex®)? _____

Breast Cancer Screening

Do you examine your own breasts for lumps? ☐ Y ☐ N	Have you ever detected a lump? ☐ Y ☐ N
Have you ever had a mammogram of your breasts? ☐ Y ☐ N	Date of last mammogram: _____
How often do you have a mammogram? ☐ Once every_____ years ☐ Once each year ☐ More than once a year?	How old were you the first time you had a mammogram? _____ How many breast biopsies have you had in your lifetime? _____

Have you ever been diagnosed with any of the following breast conditions? *(Check all that apply)*

☐ ADH (atypical ductal hyperplasia) Age: _____ ☐ ALH (atypical lobular hyperplasia) Age: _____

☐ LCIS (lobular carcinoma in situ) Age: _____

Have you ever been diagnosed with breast cancer? ☐ Y ☐ N
At what age were you first diagnosed with breast cancer? _____

If diagnosed with breast cancer, was it in one or both breasts? ☐ One ☐ Both ☐ Right ☐ Left

Notice of Privacy Practices
H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of **NOTICE OF PRIVACY PRACTICES.**
Date: _____ **Initial:**
Consent to Treat
I request and give consent to my physician to provide and perform such medical/surgical care, test, procedures, medications and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.
Initial: _____
Release of Medical Information and Authorization to Pay Insurance Benefits
I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.
Initial: _____
Medicare Certification
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.
Initial: _____
Financial Agreement
I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.
Initial: _____

Advanced Directive *(A copy may be required for your chart)*	
Do you have a **Living Will**?	☐ Y ☐ N
If yes: A copy was received by this office	Date:
Have you appointed a **Health Care Representative**?	☐ Y ☐ N
If yes: A copy was received by this office	Date:
Do you have a **Physician Order for Scope of Treatment**? (POST)	☐ Y ☐ N
If yes: A copy was received by this office	Date:

Release of Protected Health Information Via Telephone to Answering Machine or Voice Mail

I give my consent and authorization for the medical or billing staff of my physician's office to leave **Protected Health Care Information** about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Phone Number: _____ **Initial: _____**

Release of Protected Health Information To Others

I give my consent and authorization for the medical or billing staff of my physician's office to release **Protected Health Care Information** about me or for me to the people that I have listed below. I understand that I may revoke this privilege at any time by submitting my request in writing to this office.

First Name	Last Name	Relationship	Phone	Mobile Phone
1.				
2.				
3.				
4.				

Patient's Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date: _____